

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2008
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295043 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/11/2008 |
|---|---|--|--|

NAME OF PROVIDER OR SUPPLIER

MAJOR CARE HEALTH SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE

3101 PLUMAS
RENO, NV 89509

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|--|----------------------------|
| IF 000 | INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a complaint survey conducted at your facility on 4/8/08 and 4/11/08. Complaint # NV00017156, was a self reported incident of a fall. The fall was substantiated and a deficiency was cited at F327. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. | F 000 | 5/8/08 Accepted [Signature] The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. | |
| F 327 SS=D | 483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to monitor and provide hydration to a resident showing signs of dehydration. (Resident #1) Findings include: Resident #1: The resident was admitted to the facility on 1/4/08. His diagnoses included paralysis agitans, acute coronary syndrome, hypertension and dementia. His minimum data set (MDS) dated 1/8/08, indicated he had modified independence in decision making and had short term memory impairment. He had a Foley catheter in place. | F 327 | RECEIVED MAY 06 2008 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Deborah Payole

Administration

5/6/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 3101 PLUMAS RENO, NV 89509 |
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| F 327 | Continued From page 1 Record review revealed that Resident #1 exhibited signs of fluid volume depletion on admission. The form entitled Nursing Admission Evaluation and dated 1/7/08 indicated Resident #1 had longitudinal tongue furrows and dry mucous membranes. The form listed these signs as indicators of fluid volume depletion/dehydration. The record revealed the resident also had a poor appetite and swallowing difficulties. The form directed, "if any of the above indicators are present, refer to Hydration Guideline and review findings with physician if clinically indicated." Record review revealed no evidence to indicate the facility's Hydration Guideline was followed. The guideline directed staff that Resident #1 and his family were to be interviewed for a history or current signs of dehydration and diuretic use. Resident #1's use of Dyazide (a diuretic), was not documented on the initial assessment form. The guideline directed staff to obtain a specific gravity, when symptoms identified, if clinically indicated." There was no documentation that a specific gravity was obtained. Review of the guideline further directed staff that a care plan was to be developed to identify the resident's risk of dehydration, set measurable goals, and delineate intervention steps to reduce the risk of dehydration. A care plan was developed. It directed staff to "Monitor skin, labs and hydration status." No fluid intake goal was identified on the care plan although a Nutrition Risk Assessment dated 1/25/08, identified the resident as needing 1590 cc per day. The resident's total fluid intake was never recorded. Only fluids consumed with meals were recorded. | F 327 | F 327 The facility does and will continue to monitor and provide hydration to residents showing signs of dehydration. <ul style="list-style-type: none"> Resident is no longer at the facility Residents identified with dry mucous membranes or longitudinal tongue furrows will be placed on alert charting and physician and family will be notified. The hydration program has been reviewed and revised to reflect current practice. Licensed nurses and dietary staff will be educated to place residents as identified above on a documented hydration program and evaluation for 72 hours or until the issue has been resolved. Licensed nurse will report to DON and physician during the 72 hr evaluation period. The DON will track the status of the hydration program and report to the QAA committee on a quarterly basis. | 5/22/08 |

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| F 327 | <p>Continued From page 2</p> <p>There was no documentation of supplemental fluids provided to meet the Resident #1's needs.</p> <p>Record review revealed the following fluid intake during Resident #1's initial stay at the facility:</p> <p>1/5/08 - 360 cc 1/6/08 - 1280 cc 1/7/08 - 960 cc 1/8/08 - 720 cc 1/9/08 - 360 cc 1/10/08 - 560 cc 1/11/08 - 360 cc 1/12/08 - 360 cc 1/13/08 - 120 cc 1/14/08 - Resident hospitalized.</p> <p>Record review revealed that Resident #1 was ordered thickened liquids. On 1/10/08, Nursing documentation noted that the resident refused to drink the thickened liquids. His urine was described as very dark and concentrated. On 1/11/08, the resident was noted to refuse thickened liquids. His urine was described as amber. On 1/12/08, he was noted to have consumed one glass of thickened liquid and his urine was dark amber. He was noted to need a "nosey cup" for drinking. On 1/13/08, his intake of fluids was described as good but his urine was dark.</p> <p>Review of hospital records revealed that on 1/14/08, Resident #1 was admitted to the hospital after falling. He exhibited changes in his electrocardiogram. The resident's hospital record indicated he was also hypotensive secondary to dehydration. Hospital records, dated 1/16/08, indicated he had orthostatic hypotension and acute renal failure secondary to dehydration, and</p> | F 327 | | |

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| IF 327 | <p>Continued From page 3</p> <p>was receiving intravenous fluids. The note revealed that he had poor skin turgor which is a sign of dehydration.</p> <p>Resident #1 returned to the facility on 1/18/08.</p> <p>On 4/8/08, the director of nurses (DON) was interviewed. She reported that the facility provided fluids to residents throughout the day by way of supplements and fluids at medication pass. The daily total amount of these fluids should have been 1020 cc. The amount of Resident #1's intake of these fluids was not recorded. No evidence was found to indicate if the resident's daily fluid needs were met. The DON provided the Hydration Guidelines and reported that the guidelines were implemented when a resident was at risk for dehydration.</p> <p>On 4/10/08, the DON was requested to provide any evidence that Resident #1's fluid needs were met on a daily basis. She was unable to provide any additional documentation.</p> | F 327 | | |

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